Sheffield Clinical Commissioning Group

CCG Assurance Framework and Risk Register for 2013/14

Governing Body meeting

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4 July 2013

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Key messages

The report provides Governing Body with:

- the initial Assurance Framework (AF) for consideration and approval
- an overview of the processes undertaken to produce the initial AF
- the work to date to produce a new Risk Register for the CCG to capture the organisation's operational risks
- the current position in respect of risks on the Risk Register which have been assessed as very high – ie having a score of 15 or over

Assurance Framework (AF)

As this paper is discussing the Assurance Framework and Risk Register in overall terms, it is not designed to provide assurance to Governing Body on any specific risks within these documents.

Equality/Diversity Impact

Has an equality impact assessment been undertaken? NO

Which of the 9 Protected Characteristics does it have an impact on?
There are no specific issues associated with this report.

Public and Patient Engagement

There are no specific actions associated with this report.

Recommendations

Governing Body is asked to:

- Approve the initial draft of the Assurance Framework attached to this paper, both in terms of content and layout.
- Note the steps being taken to establish a new Risk Register for the CCG and the mitigating actions being taken against the current very high risk reported to this meeting.
- Approve the minor changes to the risk stratification (Appendix B), which will then be incorporated in the next draft of the Risk Management Strategy

CCG Assurance Framework and Risk Register for 2013/14

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1. INTRODUCTION

It is important to recognise the respective functions of the Assurance Framework and Risk Register for the CCG:

- The Assurance Framework is described in the Audit Committee Handbook as the main tool for the Governing Body to discharge its overall responsibility for internal control. It is the key source of evidence that enables the CCG to focus on the strategic and reputational risks that might compromise the achievement of our most important (i.e. principal) annual objectives.

- The Risk Register lists individual and routine risks anticipated by managers and clinicians and is an important operational tool for collating and analysing trends.

This paper builds on the Organisational Development session held with Governing Body members on 9 May 2013 and describes the approach taken to construct the initial CCG Assurance Framework and Risk Register for 2013/14.

2. APPROACH TO DEVELOPING THE ASSURANCE FRAMEWORK

Effective assurance depends on two key components:

A) A process, which is reliant on the following elements working together:
   - A clear understanding of the strategic objectives
   - The right governance framework and risk culture
   - Well defined internal controls that operate effectively and are aligned to the strategic objectives
   - Good data quality

B) A risk culture and environment that supports and motivates members of the Governing Body to appropriately assure themselves that effective internal controls are in place and rigorously applied.

A robust Assurance Framework should answer the following questions:

1) Have we captured only high level strategic / reputational risk (i.e. not operational risk that belong on the Risk Register)?
2) Does the Assurance Framework cover all activity and relationships?
3) Can we map out the key controls to manage the objective?
4) Have we been absolutely honest about Gaps in Controls or Assurance?
5) Are Assurances positive, evidenced and up to date?
6) Does the Assurance Framework help Governing Body determine where to make the most efficient use of resources to improve quality and safety of care?

7) Does it identify priorities to understand our capacity to deliver?

The proposed CCG Assurance Framework for 2013/14 has five principal objectives, comprising:

- the CCG's four strategic objectives set out in its Prospectus and Commissioning Intentions for 2013/14 and which underpin the CCG's 2013/14 business plan:
  - To improve patient experience and access to care
  - To improve the quality and equality of healthcare in Sheffield
  - To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
  - To ensure there is a sustainable, affordable healthcare system in Sheffield

- A fifth principal objective provides assurance of the CCG's organisational health and capability to maintain authorisation compliance for 2013 and beyond, in accordance with Annex C of *NHS England Clinical Commissioning Group Assurance Framework,* (Publication Gateway 00072).

The process adopted to produce the new Assurance Framework has involved the following:

- We have considered the principal risks with a score of 12 or above (ie high risks using the South Yorkshire and Bassetlaw risk stratification approach for 12/13) remaining at 31 March 2013 in either the PCT Cluster Assurance Framework and Sheffield CCG's own Assurance Framework for 2012/13. These are listed in Appendix A for ease of reference and all are considered sufficiently pertinent to incorporate either on the CCG's risk register or as part of the new 19 principal risks identified for inclusion in the 2013/14 Assurance Framework.

- Against each of the five objectives, lead officers have been asked to consider principal risks. A meeting held on 17 June considered and correlated views on the nature and scoring of risks from which the first draft of the 2013/14 Assurance Framework has been produced for wider consultation. It was considered by CET at its meeting on 25 June and has been circulated to internal and external auditors for comment.

- Significant work has been undertaken to improve the presentation of the Assurance Framework, providing more information to readers and in particular to assure Governing Body on the progress to reduce the risk score to the target or "appetite" risk score including key mitigating actions to address gaps in control and assurance.

3. APPROACH TAKEN TO DEVELOPING THE RISK REGISTER

Risk management should not be viewed as the responsibility of a separate function. The pressure on the CCG is not only to develop effective structures and systems to manage risks, but to ensure those systems are aligned to our internal functions, and embedded into every part of the organisation. Executive Officers have individual responsibility for an effective risk management process, but at the same time must ensure a common understanding of risk appetite throughout the workforce.

Managing risk effectively and embedding internal control into the processes is a significant function, the external driver being the Annual Governance Statement, which places public disclosure obligations on the Governing Body. The Risk Register is an integral part of the operational process, acting as a repository for all operational risk information and enabling the CCG to understand its risk profile.

Thus it is critical that the CCG, as a new statutory organisation, has an up to date risk register which is a “live” document used regularly by all its officers and lead clinicians. Work has been ongoing during Q1 to produce a new risk register with the following key steps taken:

- The PCT managed its Risk Register through ‘Datix’, a software system designed specifically for managing and controlling healthcare risk. This was not a particularly “user friendly” system. In March/April 2013 a review was undertaken of all the risks on the Datix system (included risks spanning 2006 to date). The establishment of the CCG allowed for a timely review of all the risks sitting on the Risk Register, many of which are no longer relevant to the CCG as a commissioner only organisation and with different areas of responsibility. A list of around 30 risks which might still be pertinent to the CCG was produced for review by CCG Executive leads / relevant senior managers. From this, a spreadsheet control list has been produced recording and risk rating those risks which managers considered relevant to carry forward and also adding new risks relating to the CCG from April 2013. The process “stripped out” strategic risks which are instead captured on the Assurance Framework for 2013/14. The process is on-going and via portfolio and other team meetings a wider group of clinicians and managers will be asked to review and consider. Any very high risks (ie those with a score of 15 of over) are identified for Governing Body, with an explanation and statement of mitigating actions.

- In May, CCG Senior Risk Leads (Linda Tully, Julia Newton, Idris Griffiths, supported by Sue Laing from the CSU) researched and compared a number of risk management systems and have agreed to adopt a system developed and tested in West Yorkshire CCGs and which is now available through our SLA with the West and South Yorkshire Yorkshire & Bassetlaw CSU at no additional expense to the CCG. The strengths of the system mean that operational risk management can be embedded as an integral part of the management approach to the achievement of our objectives. More importantly the system demonstrated that the management of operational risk would be seen as both a collective and individual responsibility, managed through the new processes as well as committee and management structures. The database creates a framework for continuous review of operational risks, at the same time provides assurance that identified risks are controlled and managed by identified risk leads who will sign-off the register review process and assure data quality risk management reviews. The aim is to have this implemented as soon as practical with staff receiving training in the near future.

- In the interim a control spread sheet a will act as the temporary Risk Register for which Linda Tully as Company Secretary will have overall oversight and control.

- Moving to use the risk register data base system developed in West Yorkshire, the Governing Body is asked to approve some minor changes in risk stratification as set out in appendix B.

4. VERY HIGH LEVEL RISKS (Score of 15 or over)

From the processes to date, as described in section 3 above, there are currently 25 risks identified on the Risk Register and only one has been given an initial (and current) risk score of 15 or over. None of the risks brought across from the PCT as still pertinent have been given a score of more than 12.

The risk scored as very high is the one which identifies that if the CCG is unable to generate additional QIPP savings over and above the £9.6m required to deliver the existing financial plan this will mean that we are unable to take forward a range of actions which require additional investment as listed in our Commissioning Intentions. Based on the current overall financial risk assessment at M2, it seems likely (score 4) that we will not generate additional savings and the impact on delivery of the Commissioning Intentions is therefore assessed as major (score 4).

Ref	Risk	Current Risk			Risk Owner	Mitigating Action Plan
		C	L	CxL		
13	Failure to achieve additional QIPP to allow investment in quality improvements listed in CCG Commissioning Intentions	4	4	16	COO	QIPP delivery is being closely monitored through the portfolio teams and Planning & Delivery Group. Opportunities for additional QIPP or other efficiencies will continue to be considered. Identification of additional funding sources in year eg through national grants which in particular could provide non recurrent or pump priming funding

5. NEXT STEPS

Following the July Governing Body, the CCG's Governance sub-committee will moderate the risk scoring at its meeting on 7 August, and the Audit and Integrated Governance Committee will have the opportunity at its September meeting to scrutinise the Assurance Framework, be updated on progress to implement the new risk register arrangements and to gain assurance on the work to address particularly the high level risks from the Risk Register.

Governing Body at its September meeting will be asked to approve an updated Risk Management Strategy.

6. Recommendations

Governing Body is asked to:

- Approve the initial draft of Assurance Framework attached to this paper, both in terms of content and layout
- Note the steps being taken to establish a new risk register for the CCG and the mitigating actions being taken against the current very high risk reported to this meeting
- Approve the minor changes to the risk stratification (Appendix B), which will then be incorporated in the next draft of the Risk Management Strategy

Linda Tully, Company Secretary
Julia Newton, Director of Finance

June 2013

Appendix A

Principal Risks with a score of 12 or above within South Yorkshire & Bassetlaw PCT Cluster Assurance Framework at 31 March 2013

Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
1.2	Failure to deliver the financial aspects of the QIPP agenda.	5	3	15	Continue to monitor QIPP delivery
2.4	Recent national publication of a call for retrospective Continuing Healthcare claims is expected to lead to a significant increase in claims – impacting on both staffing capacity to review the claims and on finance. The time limits for the process are very short – September 2012.	4	3	12	Implement a coordinated approach to Continuing Care retrospective claims reviews across the 5 PCTs
3.5	Failure to effectively safeguard children and vulnerable people in line with statutory requirements leading to potential harm.	5	3	15	Monitor through Cluster Risk Register and local arrangements
3.6	Failure to ensure effective workforce planning and capability leading to de-motivation of staff.	4	3	12	Undertaken a gap analysis / skills audit to ensure capacity and capability for CSU functions
6.1	Failure to effectively engage staff systematically during transition, resulting in potential de-motivation, lack of productivity and poor staff experience and including potential industrial action	4	3	12	Work to align workforce systems and processes across the localities

The assessment of CCG officers is that all of these risks remain pertinent to the CCG for 2013/14 and they have been incorporated into the principal risks proposed for inclusion in the CCG's 2013/14 Assurance Framework or Risk Register where the risk is considered more of an operational one.

Principal Risks with a score of 12 or above within Sheffield CCG Assurance Framework at 31 March 2013

AF Ref	Principal Risk	Current Risk			Action Plan
		C	L	CxL	
2.1.3	Failure to deliver QIPP programme savings and hence financial balance	4	3	12	Monthly monitoring of QIPP and overall financial performance. (post year end note – for 12/13 both delivered per draft accounts)
2.2.3	Poor quality of life and life expectancy through failure to address key joint health and wellbeing strategy areas and deliver relevant public health outcomes	4	3	12	Implementation of CCG Commissioning Intentions for 13/14; joint work with key partners eg LA via HWBB
2.4	Providers continue to generate hospital based demand preventing service reconfigurations	4	3	12	Implementation of Right First Time and elective QIPP programme going forward
3.1	Impact of organisational change on capacity to deliver	4	3	12	Planning & delivery group to oversee clinical and managerial capacity

The assessment of CCG officers is that all of these risks remain pertinent to the CCG for 2013/14 and they have been incorporated into the principal risks proposed for inclusion in the CCG's 2013/14 Assurance Framework or Risk Register where the risk is considered more of an operational one.

Appendix B
Risk Stratification for use by CCG from June 2013

Risk Matrix		Likelihood				
		-1 Rare	-2 Unlikely	-3 Possible	-4 Likely	-5 Almost certain
Consequence	-1 Negligible	1	2	3	4	5
	-2 Minor	2	4	6	8	10
	-3 Moderate	3	6	9	12	15
	-4 Major	4	8	12	16	20
	-5 Extreme	5	10	15	20	25

Score	Rating	
1 to 3	Low	We have previously had to 5
4 to 9	Medium	We have previously had to 11
10 to 14	High	we have previously had 12 to 15
15 to 19	Very High (Serious)	we have previously had 16 to 20
20 to 25	Critical	

ALL RISKS SCORING 15 OR ABOVE (IE VERY HIGH) WILL BE REPORTED TO GOVERNING BODY WITH EXPLANATIONS AND PROPOSED MITIGATING ACTIONS

NHS Sheffield CCG: Board Assurance Framework (June 2013)

Introduction

The Board Assurance Framework aims to identify the principal or strategic risks to the delivery of the CCG's strategic objectives. It sets out the controls that are in place to manage the risks and the assurances that show if the controls are having the desired impact. It identifies the gaps in control and hence the key mitigating actions required to reduce the risks towards the target or appetite risk score. It also identifies any gaps in assurance and what actions can be taken to increase assurance to the CCG.

The table below sets out the strategic objectives lists the various principal risks that relate to them and highlights where gaps in control or assurance have been identified. Further details can be found on the supporting pages for each of the Principal Risks.

Strategic Objective	Principal Risk identified	Risk Owner	Risk Initial Score	Risk Current Score	Risk Target or Appetite Score	Are there GAPS in control?	Are there GAPS in assurance ?
1. To improve patient experience and access to care	1.1 Loss of public confidence in the CCG through poor communications (Domain 2)	IG		12	6	Yes	Yes
	1.2 Insufficient engagement with patients and the public on CCG priorities and in their participation leading to inappropriate use of NHS services and self-care (Domain 2)	TF	12	9	6	Yes	Yes
	1.3 System wide or specific provider capacity problems emerge to prevent delivery of NHS Constitution and/or NHS E required pledges (Domain 3)	IG	12	9	6	Yes	No
2. To improve the quality and equality of healthcare in Sheffield.	2.1 Providers delivering poor quality care and not meeting quality targets (Domain 4)	KC	9	9	6	Yes	No
	2.2 Inappropriate eligibility for Continuing Health Care leading to an excess demand for NHS funded services - including retrospective assessments (Domain 4)	KC	9	6	6	No	Yes
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield	3.1 Health & Well Being Board unable to support CCG Business Plan(Domain 3)	TF	9	6	3	Yes	Yes
	3.2 Budgetary constraints faced by Sheffield City Council result in actions by a key partner which adversely impact on CCG's ability to implement its priorities	JN	16	16	6	Yes	No
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.	4.1 Ineffective commissioning practices (Domain 3)	TF	9	9	3	Yes	Yes
	4.2 Commissioned care does not reflect best practice and service changes are not devised with sufficient clinical engagement. (Domain 3)	ZM/ RO	9	6	3	Yes	Yes
	4.3 Overly ambitious Financial Plan and insufficient financial management (Domain 3)	JN	12	9	6	Yes	No
	4.4 CCG commissioning responsibilities and funding not aligned following the disaggregation of PCT responsibilities (Domain 3)	JN	9	6	4	No	No
	4.5 Inability to secure partnerships that help us to deliver our commissioning plans including QIPP and/or conflicting priorities.(Domain 3)	TF	9	6	3	Yes	N0
	4.6 Unable to increase capacity in primary and community care in parallel to reducing acute capacity.(Domain 3)	ZM/ RO	16	12	8	Yes	N0

NHS Sheffield CCG: Board Assurance Framework (June 2013)

Strategic Objective	Principal Risk identified	Risk Owner	Risk Initial Score	Risk Current Score	Risk Target or Appetite Score	Are there GAPS in control?	Are there GAPS in assurance ?
5. Organisational development to ensure CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)	5.1 CSU unable to provide timely and appropriate support (Domain 3)	IG	12	9	6	Yes	No
	5.2 Inability to secure active participation particularly from Member Practices for delivering CCG priorities(Domain 1, 3,5)	LT	16	12		No	No
	5.3 Ineffective succession planning for clinical engagement (Domain 1, 4)	LT	9	9	6	No	No
	5.4 Inability to develop appropriately skilled leadership and workforce throughout the CCG (Domain 6)	LT	9	9	6	No	No
	5.5 Inadequate adherence to CCG Constitution and other governance arrangements to support Nolan Principles and e.g. protect against conflicts of interests (Domain 4)	LT	12	12	4	No	No

The Risk Ratings used in the Assurance Framework are based on the following risk stratification table:

Risk Matrix		Likelihood: -1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Consequence	-1 Negligible	- 1	- 2	- 3	- 4	5
	-2 Minor	2	4	6	8	10
	-3 Moderate	3	6	9	12	15
	-4 Major	4	8	12	16	20
	-5 Extreme	5	10	15	20	25

Score	Rating
1 to 3	Low
4 to 9	Medium
10 to 14	High
15 to 19	Very High (Serious)
20 to 25	Critical

NHS Sheffield CCG: Board Assurance Framework (June 2013)

Principal Objective: To improve patient experience and access to care

Director lead: Chief Operating Officer: (Idris Griffiths)

Principal Risk: 1.1 Loss of public confidence in the CCG through poor communications (Domain 2)

Date last reviewed: 24 June 2013

Risk Rating (likelihood x consequence):

Initial: 4x3=12

Current: 4x3=12

Appetite:3x2=6

Rationale for current score:

Communication service requires further development

Rationale for risk appetite:

Excellent communications is essential to establish public confidence

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*

CCG has agreed its communication strategy

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)***:**

We need and action plan and assurance process with regard to delivery

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
A communications action plan is being established and additional resource allocated by CSU	July 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- Report to CET

Positive Assurance: *(Provide specific evidence of Assurances)*

- Established weekly operational meetings (from 21 June)

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

Direct feedback from the public

Principle Risk Reference: 1.1

Principal Objective: To improve patient experience and access to care

Director lead: Director of Business Planning & Partnerships: (Tim Furness)

Principal Risk: 1.2 Insufficient engagement with patients and the public on CCG priorities and in their participation leading to inappropriate use of NHS services and self-care (Domain 2)

Date last reviewed: 24 June 2013

Risk Rating (likelihood x consequence):

Initial: 4x3 = 12

Current:3x3 =9

Appetite:2x3 =6

Rationale for current score:

It is likely that, in a new organisation with new ways of working, there is insufficient engagement. Feedback from patient reps, based on PCT working, confirms that. Work to date – engagement principles, public meeting – reduces that likelihood.

Rationale for risk appetite:

We should have mechanisms in place that make effective engagement routine and therefore the likelihood of failure to engage "unlikely" at worst

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*

Communication and engagement strategy

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:

We need to develop working practices and protocols to put the strategy into practice

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Meeting with members of the public 4/7/13 to discuss how they wish to be engaged.	4/7/13
Engagement action plan – to implement strategy – to GB in September (as no August GB)	5/9/13

Assurances: *(Where should we find the evidence that controls are effective?)*

- Business cases and GB papers should describe engagement and result of it

Positive Assurance: *(Provide specific evidence of Assurances)*

- None as yet

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

Communication and engagement strategy only recently adopted. Too early for reports on activity. As further controls not yet in place, assurance cant' yet be given

Principle Risk Reference: **1.2**

Principal Objective: To improve patient experience and access to care

Director lead: Chief Operating Officer: (Idris Griffiths)

Principal Risk: 1.3 System wide or specific provider capacity problems emerge to prevent delivery of NHS Constitution and/or NHS E required pledges (Domain 3)

Date last reviewed: 24 June 2013

Risk Rating

(likelihood x consequence):

Initial: 4x3=12

Current: 3x3=9

Appetite: 2x3=6

Rationale for current score:

Inefficient patient flow through the system can significantly impact on waiting times e.g. 18 weeks and A&E 4 hours

Rationale for risk appetite:

Consequences of capacity problems can have significant impact on patient experience and these need to be mitigated with effective planning and partnership work

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
Partnership work through Right First Time

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:

More forward planning e.g. winter

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Established urgent care Board	June 2013
Agree A&E action plan	June 2013
Draft winter plan produced	July 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- Quality & Outcomes Report to Governing Body

Positive Assurance: *(Provide specific evidence of Assurances)*

- Urgent Care Board ToR and Action Plan reported to Governing Body June 2013

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

No current gaps – to be reviewed

Principle Risk Reference: **1.3**

Principal Objective: To improve the quality and equality of healthcare in Sheffield

Director lead: Chief Nurse: (Kevin Clifford)

Principal Risk: 2.1 Providers delivering poor quality care and not meeting quality targets (Domain 4)

Date last reviewed: 18th June 2013

Risk Rating

(likelihood x consequence):

Initial: 3x3=9

Current: 3x3=9

Appetite: 2x3=6

Rationale for current score:

The impact of the Francis (2) review has not yet fully been assessed by Sheffield providers and thus the CCG requires more assurance that the culture of services that we commission is focused on the safety and wellbeing of patient/service users.

Rationale for risk appetite:

To get to a position where the consequence is moderate and although there will always be risks to patient safety and poor quality care, that the impact on patient outcomes and experience is reduced.

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)* National and Local Policy/ regulatory standards; CQC regulations, SI, Infection Control, Safeguarding procedures, NICE/Quality Standards, Patient Surveys, Quality standards in Contracts, Contract Quality Review Groups

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:
The CCG needs to have a commissioning for quality strategy that will deliver the required actions from national directives and reviews and describe how we hold providers to account for quality.

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Development of a CCG Quality Strategy and supporting strategies - incorporating actions from national reviews	Jan 2014

Assurances: *(Where should we find the evidence that controls are effective?)*

- CQC inspections of providers and provider action plans, provider data and annual reports SI investigation reports, Serious Case Reviews, Clinical Audit reports, Internal audit benchmarking data, provider Governance Meetings, site visits, CCG Commissioning Groups, CCG quality dashboards.

Positive Assurance: *(Provide specific evidence of Assurances)*

- Quality Assurance Committee Minutes, Serious Incident reports, Safeguarding reports, Patient Experience /Complaints reports, data on quality targets, exception reports to Governing Body Quarterly

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

No

Principle Risk Reference: **2.1**

Principal Objective: To improve the quality and equality of healthcare in Sheffield

Director lead: Chief Nurse: (Kevin Clifford)

Principal Risk: 2.2 Inappropriate eligibility for Continuing Health Care leading to an excess demand for NHS funded services - including retrospective assessments (Domain 4)

Date last reviewed: 18th June 2013

Risk Rating

(likelihood x consequence):

Initial 3x3 =9

Current:2x3 =6

Appetite: 2x3=6

Rationale for current score:

There remains a level of disagreement with Sheffield City Council preventing a full shared understanding and application of the National Frame work. CCG now has strong controls to ensure consistent and appropriate eligibility decisions.

Rationale for risk appetite:

Targeting a lower level of risk could have consequential impact elsewhere in the system e.g. home of choice.

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:

No

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date

Assurances: *(Where should we find the evidence that controls are effective?)*

- Data on CHC eligibility. National and Yorkshire benchmarking, Monthly Executive review of activity and finance. Minutes of committee meetings, Escalation reports.

Positive Assurance: *(Provide specific evidence of Assurances)*

- Governing Body Exception Reports, CET/Planning and Delivery Exception reports

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

A small number of areas of disagreement remain with SCC preventing a full shared understanding and application of the National Frame work

Principle Risk Reference: 2.2

Principal Objective: To work with Sheffield City Council to continue to reduce health inequalities in Sheffield	**Director lead:** Director of Business Planning & Partnerships: (Tim Furness)
Principal Risk: 3.1 Health & Well Being Board unable to support CCG Business Plan (Domain 3)	**Date last reviewed:** 24 June 2013

Risk Rating

(likelihood x consequence):

Initial:3x3 = 9

Current: 2x3 = 6

Appetite: 1x3 = 3

Rationale for current score:

Initial likelihood was "possible" as HWB was newly established and relationships developing. Recent work has led to HWB support of current CCG commissioning plans. Therefore current risk of future lack of support "unlikely".

Rationale for risk appetite:

We should aim to have a close enough understanding of each other's business, and have aligned plans for health and care that focus on people's needs, that the prospect of the HWB not supporting CCG plans is "rare".

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*

Four GB GPs active members of HWB

HWB forward plan.

Current commissioning intentions describe how plans meet HWB strategy

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)***:**

Plan for developing 14/15 plans needs to be explicit about how HWB engaged and support gained

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
HWB forward plan includes discussion of partners' commissioning plans, following agreement of the joint Health and wellbeing strategy	Nov & Dec 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- Minutes of HWB
- Chair and/or Chief Officer reports

Positive Assurance: *(Provide specific evidence of Assurances)*

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

Minutes of HWB are not routinely received by GB. GB may wish to receive this additional assurance

Principle Risk Reference: **3.1**

Principal Objective: To work with Sheffield City Council to continue to reduce health inequalities in Sheffield	**Director lead:** Director of Finance: (Julia Newton)
Principal Risk: 3.2 Budgetary constraints faced by Sheffield City Council result in actions by a key partner which adversely impact on CCG's ability to implement its priorities	**Date last reviewed:** 17 June 2013

Risk Rating (likelihood x consequence):

Initial: 4x4=16

Current: 4x4=16

Appetite: 2x2=4

Rationale for current score:

Discussions with SCC on managing their inability due to serious budgetary constraints, to extend social care services and to respond positively to Right First Time changes need to be progressed further before the risk rating can be reduced.

Rationale for risk appetite:

CCG needs to get to a position where it can be sure that impact is unlikely and minor to be able to press ahead with service redesign with confidence.

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*

Joint director level meetings with SCC;RFT Board; S256 agreements; HWBB

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:

More formal integrated financial planning and risk sharing arrangements

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Improved financial risk sharing arrangements with SCC in particular re. impact of Right First Time	Sept 2013
Increased joint financial planning for 14/15 and beyond	Jan 2014

Assurances: *(Where should we find the evidence that controls are effective?)*

- RFT Board minutes; Audit of RFT

Positive Assurance: *(Provide specific evidence of Assurances)*

- Updates to Board monthly on CCG Finance position and on RFT

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

N/A

Principle Risk Reference: **3.2**

Principal Objective: To ensure there is a sustainable, affordable healthcare system in Sheffield.

Director lead: Director of Business Planning & Partnerships: (Tim Furness)

Principal Risk: 4.1 Ineffective commissioning practices (Domain 3)

Date last reviewed: 24 June 2013

Risk Rating
(likelihood x consequence):
Initial: 3x3=9
Current: 3x3=9
Appetite: 1x3 =3

10
5
0
Risk Score
Risk Appetite
Apr-13
Q1 2013/14

Rationale for current score:
As a result of profound organisational change and adoption of new ways of working, it is possible that some of the good commissioning practice used by the PCT has stopped being routinely used.

Rationale for risk appetite:
Organisational and staff development should result in clinicians and staff being familiar with best practice.

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
OD programme. Staff development activities.

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)***:** Business processes do not always prompt and ensure rigorous application of good commissioning practices. The OD steering group should consider the development and adoption of best practice

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
New business case template adopted, prompting use of good practice	June 2013
Development of 2014/15 commissioning plans should reflect best practice	Sept-Dec 2013
On-going OD and staff development	

Assurances: *(Where should we find the evidence that controls are effective?)*
- Business cases and papers to GB should reflect good practice
- Reports on OD

Positive Assurance: *(Provide specific evidence of Assurances)*
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Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*
OD reports to GB do not yet reflect development of best commissioning practice

Principle Risk Reference: **4.1**

Principal Objective: To ensure there is a sustainable, affordable healthcare system in Sheffield.

Director lead: Joint Clinical Directors: (Richard Oliver/Zak McMurray)

Principal Risk: 4.2 Commissioned care does not reflect best practice and service changes are not devised with sufficient clinical engagement (Domain 3)

Date last reviewed: 24 June 2013

Risk Rating

(likelihood x consequence):

Initial: 3x3=9

Current: 2x3=6

Appetite:1x3 =3

Rationale for current score: Commissioned services should reflect best evidence, and pathway changes must have credibility with both secondary and primary care clinicians. Consistent adoption of best practice in patient care (e.g. referral pathways) is more likely if commissioning decisions have been made with clinical involvement. We have a number of mitigating actions in place; however we need to ensure greater breadth and depth of engagement.

Rationale for risk appetite:

Clinical engagement and service transformation are at the heart of the CCG's purpose, therefore risks in this area need to be minimised.

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)* Clinical Reference Group (CRG) led by Clinical Directors. PLI events reinforce new pathways, protocols etc. Budget set aside to support engagement by funding locum backfill. Portfolios are securing clinical advice above and beyond formal leadership. PRESS portal supports dissemination of new pathways.

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*: We need to develop the CRG to draw in more clinicians, to ensure through debate that will follow through to action, and to ensure that no proposals come to CET / P&DG without clinical engagement through CRG.

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
New pathway change process sponsored by Clinical Director reinforces role of CRG and re-affirms the need to ensure that commissioning decisions are underpinned by evidence e.g. NICE, SIGN and Map of Medicine.	July 2013
Clinical Directors devising work plan for CRG to re-invigorate its work and draw new people in	August 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- Business cases and commissioned pathways reflect good practice
- Activity monitoring demonstrates shifts in referral

Positive Assurance: *(Provide specific evidence of Assurances)*

- P&DG / CET papers; Governing Body performance reports
- Twice yearly CRG report to Governing Body, May and November

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

We are currently evaluating the clinical impact of our PLI programme but this work is not yet complete.

Principle Risk Reference: **4.2**

Principal Objective: To ensure there is a sustainable, affordable healthcare system in Sheffield.

Director lead: Director of Finance: (Julia Newton)

Principal Risk: 4.3 Overly ambitious Financial Plan and insufficient financial management (Domain 3)

Date last reviewed: 17 June 2013

Risk Rating

(likelihood x consequence):

Initial: 4x3=12

Current: 3x3=9

Appetite: 2x3=6

Rationale for current score:

At end of Q1 still limited data to start to assess whether financial plan as approved by Governing Body in April is overly ambitious. In addition CCG is at early stages of embedding financial systems via SBS and new policies/procedures – hence risk left as high

Rationale for risk appetite:

Need to move to position where more stress testing of financial plan in different scenarios and the new financial systems/procedures are fully embedded

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
Plans scrutinised by Governing Body; detailed monthly financial reports produced; CCG has SOs, Prime Financial Policies and other detailed financial policies and procedures

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:
Additional scenario and contingency work around the financial plan

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Develop further contingency plans to manage up and down side risk in financial plan and discuss with CET/Governing Body	Sept 13

Assurances: *(Where should we find the evidence that controls are effective?)*

- NHS E review of financial plan and monthly review of in year financial position; reviews on financial systems/processes by internal and external audit; external audit VFM reviews

Positive Assurance: *(Provide specific evidence of Assurances)*

- Monthly reports to Governing Body

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

None

Principle Risk Reference: **4.3**

Principal Objective: To ensure there is a sustainable, affordable healthcare system in Sheffield.

Director lead: Director of Finance: (Julia Newton)

Principal Risk: 4.4 CCG commissioning responsibilities and funding not aligned following the disaggregation of PCT responsibilities (Domain 3)

Date last reviewed: 17 June 2013

Risk Rating

(likelihood x consequence):

Initial: 3x3=9

Current: 3x2=6

Appetite: 2x2=4

Rationale for current score:

CCG has put in place controls with key other commissioners i.e. NHS E, SCC and other CCGs to understand and manage consequences. Impact on CCG financial plan at end of Q1 is now assessed as minor as opposed to moderate at start of year due to further work with other commissioners.

Rationale for risk appetite:

CCG needs to have a position where good alignment (and understanding of this alignment) in terms of its responsibilities and funding in order to discharge these responsibilities within its budget

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)* Joint processes with NHS E, SCC and other CCGs to understand budgets and respective responsibilities; CCG Com; national exercise at M4 on specialised services

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:
None

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Complete M4 exercise with NHS E re. specialised services	July 2013
Complete national NHS Property Services reconciliation exercise on recharged costs	Oct 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- NHS E led reviews; audit reviews

Positive Assurance: *(Provide specific evidence of Assurances)*

- Monthly finance reports to Governing Body

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

None

Principle Risk Reference: **4.4**

Principal Objective: To ensure there is a sustainable, affordable healthcare system in Sheffield.

Director lead: Director of Business Planning & Partnerships: (Tim Furness)

Principal Risk: 4.5 Inability to secure partnerships that help us to deliver our commissioning plans including QIPP and/or conflicting priorities (Domain 3)

Date last reviewed: 24 June 2013

Risk Rating (likelihood x consequence):

Initial: 3x3=9

Current: 2x3=6

Appetite: 1x3=3

	Apr-13	Q1 2013/14
Risk Score	9	6
Risk Appetite	3	3

Rationale for current score:

The CCG has developed partnerships over the last 12 months, within Sheffield and across SY and Y&H, which have established common priorities and workplans. The likelihood of this risk is therefore reduced from the initial “possible” to “unlikely”

Rationale for risk appetite:

We should aspire to establish relationships with partners that mean that it is most unlikely that those partnerships do not help us deliver our plans.

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
Partnership structures - HWB, Right First Time& Future Shape Children’s Services programmes, SYCOM & CCGCOM

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:

There are instances of programmes not achieving objectives, indicating we need to support and influence the programmes more

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Continued development of focus of CCGCOM and development of Y&H CCG partnerships	June-July 2013
Active engagement in RFT and FSC, ensuring CCG plays it’s part in delivering aims (e.g. Care Planning)	June 2013
Alignment of commissioning priorities with SCC to support RFT and FSC through HWB	Autumn 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- Reports on RFT and FSC programmes. Minutes of SY COM and CCGCOM

Positive Assurance: *(Provide specific evidence of Assurances)*

- Monthly performance reports demonstrate progress of partnerships on key QIPP and other priorities

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

Principle Risk Reference: 4.5

Principal Objective: To ensure there is a sustainable, affordable healthcare system in Sheffield.

Director lead: Joint Clinical Directors: (Richard Oliver/Zak McMurray)

Principal Risk: 4.6 Unable to increase capacity in primary and community care in parallel to reducing acute capacity (Domain 3)

Date last reviewed: 24 June 2013

Risk Rating (likelihood x consequence):

Initial: 4x4 =16

Current: 3x4 = 12

Appetite: 2x4 = 8

Rationale for current score:

Plans are in place through the Right First Time (RFT) partnership programme (e.g. GP Associations, Integrated Care Teams) and the Joint Board with STH to address community nursing capacity. This area remains a significant risk to plans for clinical transformation.

Rationale for risk appetite:

In order to deliver the major changes in provision we aspire to, the CCG needs to maintain clinical service resilience and public and stakeholder confidence, therefore this risk needs to be minimised as far as possible.

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)* Right First Time project structures and clinical leadership. Involvement of our Chief Nurse and one of the Joint Clinical Directors in the Joint Board. Additional CCG investment in community nursing, risk stratification and GP Association development.

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:

Some areas are not within our direct control and can only be influenced through the city wide partnership. The investment we have made may not deliver change at the pace required.

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Significant service redesign and demand management activity to support greater efficiency and integration via the RFT approach	Ongoing

Assurances: *(Where should we find the evidence that controls are effective?)*

- RFT impact metrics 2) Delivery of in year QIPP savings

Positive Assurance: *(Provide specific evidence of Assurances)*

- RFT reports to Governing Body

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

Principle Risk Reference: 4.6

Principal Objective: Organisational development to ensure CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)

Director lead: Chief Operating Officer: (Idris Griffiths)

Principal Risk: 5.1 CSU unable to provide timely and appropriate support (Domain 3)

Date last reviewed: 24 Jun 2013

Risk Rating

(likelihood x consequence):

Initial: 4x3=12

Current: 3x3=9

Appetite: 3x2=6

Rationale for current score:

Performance management controls are established but need to be embedded

Rationale for risk appetite:

Effective commissioning support is essential for effective working of CCG

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)***:** Need to improve understanding of working relationships between the two organisations.

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Joint staff event for CCG and CSU staff; Building for Partnership	27June
Established targeted action plans for areas where performance needs addressing	July 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- Monthly performance reviews with CSU reported at joint director level (CCG/CSU meeting)

Positive Assurance: *(Provide specific evidence of Assurances)*

- Monthly performance reviews to joint directors (14 June 2013)

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

None – recurrently kept under review

Principle Risk Reference: 5.1

Principal Objective: Organisational development to ensure CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)

Director lead: Company Secretary: (Linda Tully)

Principal Risk: 5.2 Inability to secure active participation particularly from Member Practices for delivering CCG priorities (Domain 1, 3,5)

Date last reviewed: 17 June 2013

Risk Rating
(likelihood x consequence):
Initial: 4x4=16
Current: 3x4=12
Appetite: 1x4=4

Rationale for current score:
With these actions taken, how serious is the problem?
All 88 practices have signed the constitution, and good level of active engagement from some GPs. Some concern regarding how sustainable the current level of engagement is.

Rationale for risk appetite:
Authorisation is reliant on sign up from all Member Practices

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
OD Strategy with development programmes in place. CCG Structure includes GP involvement at Gov Body and its associated Committees, CET and CRG. H&W Being Board.

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*: Need to plan for financial resourcing of additional capacity and future development requirements.

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Members Council Meeting	16 Oct 2013
Skills register to identify development needs	October 2013

Assurances: *(Where should we find the evidence that controls are effective?)*
- Governing Body Reports 2) OD Steering Group Minutes 3) OD Evaluation Reports to OD Steering Group 4) Response to Election Process

Positive Assurance: *(Provide specific evidence of Assurances)*
- OD steering Group forward Planner (July 2013).
- Governing Body reports April, May 2013.
- Evaluation from Sheffield University leadership Programme July 2013

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*
None

Principle Risk Reference: **5.2**

Principal Objective: 5. Organisational development to ensure CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)	**Director lead:** Company Secretary: (Linda Tully)
Principal Risk: 5.3 Ineffective succession planning for clinical engagement (Domain1, 4)	**Date last reviewed:** 24 June 2013

Risk Rating (likelihood x consequence):
Initial: 3x3 =15
Current: 3x3=9
Appetite: 2x3=6

Rationale for current score:
Good governance depends on continuity of leadership and clinical engagement

Rationale for risk appetite:
Authorisation is dependent on demonstrable clinical engagement

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)*
OD Programme. Communication Strategy. Election Process. Evaluation reports from OD events

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:
No gaps

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Members Council Meeting	16 Oct 2013

Assurances: *(Where should we find the evidence that controls are effective?)*
- Governance Board Papers
- Forward Planners
- OD event evaluations

Positive Assurance: *(Provide specific evidence of Assurances)*
- Governance Reports to Governing Body April and May 2013.

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*
No gap

Principle Risk Reference: 5.3

Principal Objective: Organisational development to ensure CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)

Director lead: Company Secretary: (Linda Tully)

Principal Risk: 5.4 Inability to develop appropriately skilled leadership and workforce throughout the CCG (Domain 6)

Date last reviewed: 24 June 2013

Risk Rating (likelihood x consequence):

Initial: 3x3 =9

Current: 3x3=9

Appetite: 2x3=6

Rationale for current score:

Good governance depends on appropriately skilled leadership

Rationale for risk appetite:

Authorisation is dependent on demonstrable clinical leadership

Existing Controls: *(What are we doing about the risk prior to any new mitigating actions?)* OD Strategy to develop leadership effectively distributed throughout the culture of the CCG/ Processes for two-way accountability in place.

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:

No gaps

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Members Council Meeting	16 Oct 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- Governance Board Papers
- Forward Planners
- OD event evaluations
- Governance Structure including Members Council and LEGs
- Robust Constitution

Positive Assurance: *(Provide specific evidence of Assurances)*

- Governance Report to Governing Body May 2013

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

No gaps

Principle Risk Reference: **5.4**

NHS Sheffield CCG: Board Assurance Framework (June 2013)

Principal Objective: Organisational development to ensure CCG meets organisational health and capability requirements set out in the 6 domains (Annex C NHS England CCG Assurance Framework)

Director lead: Company Secretary: (Linda Tully)

Principal Risk: 5.5 Inadequate adherence to CCG Constitution and other governance arrangements to support Nolan Principles and e.g. protect against conflicts of interests (Domain 4)

Date last reviewed: 24 June 2013

Risk Rating

(likelihood x consequence):

Initial: 3x4 =12

Current: 3x4=12

Appetite: 1x4=4

Rationale for current score:

Good governance in Public Life is guided by the Nolan Principles. CCG have a unique challenge in being both providers and commissioners of health services.

Rationale for risk appetite:

Authorisation is dependent on robust constitutional arrangement

Existing Gaps in Control: *(Where are we failing to put controls in place and what more should we do?)*:

No gaps

Mitigating actions: *(What new controls are to be put in place to address Gaps in Control and by what date?)*

Action	Date
Members Council Meeting	16 Oct 2013

Assurances: *(Where should we find the evidence that controls are effective?)*

- Governance Board Papers
- Forward Planners
- OD event evaluations
- Governance Structure including Members Council and LEGs
- Robust Constitution

Positive Assurance: *(Provide specific evidence of Assurances)*

- Governance papers to Governing Body: April 2013 reviewed policies, May 2013 Members agreed changes to constitution

Gaps in assurance: *(Where are we failing to gain evidence that our controls are effective?*

No gaps

Principle Risk Reference: **5.5**